

TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

January 1, 1997

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR Part 44 Subpart C

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A Part 1 Pages 112(f), 145, 149(a),
149(a)(1), 149(e), 153(b), 161, 161(a), 161(b), 162, 163
163(a), 164, 165, 165(a), 165(b), 165, 167, 168, 168(b),
168(b), 211, 211(a), 213, 214, 215, 216, 217, 230(a), 250

*** SEE REMARKS

7. FEDERAL BUDGET IMPACT:

a. FFY 1996-1997 \$ 0

b. FFY 1997-1998 \$ 0

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19-A Part 1 Pages 112(f), 145,
149(a), 149(a), 153(a), 161, 161(a), 161(b), 162,
163, 164, 165, 165(a), 165(b), 165, 167, 168, 168(a),
213, 214, 215, 216, 217, 230(a), 250
40 Previous Pages 149(a)(1), 163(b), 165(b),
166(a), 168(b)

10. SUBJECT OF AMENDMENT:

Inpatient Hospital Services

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Barbara A. DeBuono, M.D., M.P.H.

14. TITLE:

Commissioner

15. DATE SUBMITTED:

March 31, 1997

16. RETURN TO:

New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

New York
112(f)

86-1.52 (3/97)
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the emergency room by the statewide change in non-Medicare inpatient admissions through the emergency room determined pursuant to item (i) of this subclause.

(iii) The hospital-specific allocation shall be determined by multiplying the proportionate hospital-specific change in non-Medicare inpatient admissions through the emergency room determined pursuant to item (ii) of this subclause by \$7.2 million.

(e) \$250 per bed for recruiting and retaining health care personnel shall be allocated to the costs of each general hospital having less than 201 certified acute nonexempt inpatient beds as of June 30, 1990 and which meets one of the following criteria:

(1) The hospital is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) since the hospital is located in a rural area as defined by federal law (see 42 U.S.C. section 1395 ww(d)(2)(D)) or defined as a rural hospital under state law; or

(2) The hospital meets the Federal definition of "sole community hospital" as defined in federal law (see 42 U.S.C. section 1395 ww(d)(5)(d)(iii)).

~~[(f) Any portion of the total not allocated in accordance with clauses (a) through (e) of this subparagraph shall be reallocated to further fund the adjustments specified in clauses (c) and (d) of this subparagraph and subdivision (c) of section 86-1.82 of this Subpart in the same proportion as the original funding.]~~

(v) Special additional inpatient operating costs equal to approximately \$167 million shall be distributed to all hospitals licensed under article 28 of the Public Health Law that are reimbursed according to the provisions of this Subpart through additions to the 1994 reimbursable costs used to calculate the case-based payment rates for rate year 1994 pursuant to subdivisions (a) and (b) of section 86-1.54 of this Subpart and such additions shall be trended to subsequent rate years. Such amounts shall be allocated as follows:

(a) \$46 million shall be allocated to the costs of general hospitals for treatment of tuberculosis patients. Amounts allocated to each general hospital shall be based on the general hospital share of the statewide total non-Medicare inpatients with tuberculosis and discharged during the period July 1, 1992 through June 30, 1993 and classified to diagnosis related groups

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Date

JAN 01 1997

97-06

44-06

86-1.58 Trend Factor. (a) The commissioner shall establish trend factors for hospitals to project the effects of price movements on historical operating costs. Rates of payment excluding capital, as calculated pursuant to the provisions of section 86-1.52 of this Subpart, shall be trended to the applicable rate year by the trend factors developed in accordance with the provisions of this section.

(b) The methodology for establishing the trend factors shall be developed by a panel of four independent consultants with expertise in health economics or reimbursement methodologies for health-related services appointed by the commissioner.

(c) The methodology shall include the appropriate external price indicators and the data from major collective bargaining agreements as reported quarterly by the Federal Department of Labor, Bureau of Labor Statistics, for non-supervisory employees.

(d) The commissioner shall implement one ~~[prospective]~~ interim ~~[annual]~~ adjustment to the trend factors, based on recommendations of the panel, ~~[effective on January first, one year after the initial trend factor was established]~~ and one ~~[prospective]~~ final ~~[annual]~~ adjustment to the trend factors based on recommendations of the panel ~~[to be effective on January first, two years after the initial trend factor was established]~~. Such adjustment shall reflect the price movement in the labor and non labor components of the trend factor. At the same time adjustments are made to the trend factors in accordance with this subdivision, adjustments shall be made to all inpatient rates of payment affected by the adjusted trend factor.

(e) Trend factors used to project reimbursable operating costs to the rate period April 1, 1995 to December 31, 1995 shall not be applied in the development of the rates of payment. This section shall not apply to trend factors, adjusted trend factors or final trend factors used for the January 1, 1995 to December 31, 1995 rate period for purposes of projecting allowable operating costs to subsequent rate periods.

(f) Trend factors used to project reimbursable operating costs to the rate period commencing April 1, 1996 and thereafter, shall not be applied in the development of the rates of payment. This section shall not apply to trend factors or final trend factors used for the January 1, 1995 to December 31, 1995 or January 1, 1996 to March 31, 1996 rate period for purposes of projecting allowable operating costs to subsequent rate periods.

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Supersedes TN **96-26** Effective Date **JAN 01 1997**

For the rate period July 1, 1994 through December 31, 1994, the maximum allowable increase in the non-Medicare statewide average reported case mix in an historical rate year shall not exceed, on a cumulative basis when taking into consideration the rate of growth between the 1992 and 1987 rate years, six and two tenths percent from the adjusted 1992 non-Medicare statewide average reported case mix for 1994. For the rate period January 1, 1995 through March 31, 1995, the maximum allowable increase in the non-Medicare statewide average reported case mix shall not exceed, on a cumulative basis, three percent from the 1992 non-Medicare Statewide average case mix. For the rate period April 1, 1995 through December 31, 1995, the maximum allowable increase in the non-Medicare statewide average reported case mix shall not exceed, on a cumulative basis, two percent from the 1992 non-Medicare statewide average reported case mix. For the rate period January 1, 1996 through ~~March 31, 1997~~ December 31, 1996, the maximum allowable increase in the non-Medicare statewide average reported case mix shall not exceed, on a cumulative basis, three percent from the 1992 non-Medicare statewide average reported case mix.

The maximum allowable increase shall be applied to adjust rates of payment for the periods commencing January 1, 1990 and ending December 31, 1996 ~~[thereafter]~~, using the following methodology:

(i) the case mix adjustment percentage determined pursuant to this subparagraph plus the case mix adjustment percentage determined for the 1992 rate year, and further plus an adjustment to reflect the difference in measurement of the percentage change from 1992 rather than 1987 to maintain the effective maximum rate of allowable increase in non-Medicare statewide average case mix at two percent from 1987 for 1988 and one percent per year thereafter except for the period July 1, 1994 through December 31, 1995 as noted above; shall be multiplied by the hospital specific average reimbursable operating cost per discharge, the group average reimbursable operating cost per discharge and the basis malpractice insurance cost per discharge and the result subtracted from such amount before application of the service intensity weight for the applicable rate year determined pursuant to section 86-1.63 of this Subpart.

(a) A reported non-Medicare statewide increase in case mix index shall be determined by dividing the statewide rate year case mix index determined pursuant to paragraph (4) of subdivision (b) of section 86-1.75 by the statewide base year case

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Supersedes TN 96-26

Effective Date JAN 01 1997

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149(a)(1).

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mix index determined pursuant to paragraph (2) of subdivision (b) of section 86-1.75 and subtracting one from the result.

(b) An estimated real non-Medicare statewide increase in case mix index shall be determined by dividing the estimated real rate year case mix index determined pursuant to paragraph (6) of subdivision (b) of section 86-1.75 by the estimated real statewide base year case mix index determined pursuant to paragraph (6) of subdivision (b) of section 86-1.75 and subtracting one from the result.

TN **97-06** Effective Date **JUN 06 2001**
Supersedes TN **New** Effective Date **JAN 01 1997**

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153(b)

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(l) Adjustments to rates made pursuant to this section shall be made prospectively, and for rate periods commencing January 1, 1997 and thereafter, may be made prospectively or retrospectively, based on the methodology for calculation of rates of payment for such prospective rate period.

(m) Hospitals may appeal the determination of allowable cumulative increases in case mix for the rate year pursuant to section 86-1.60 of this Subpart based on such factors as changes in hospital service delivery and referral patterns. An appeal pursuant to this section must be submitted within 90 days of receipt of notice of such determination and any modified rate certified pursuant to this subdivision shall be effective as of the date of the case mix adjustment.

(n) The appeal process shall be in accordance with section 86-1.17(c), (e) and (f) of this Subpart, provided, however, that documentation sufficient to support such appeal, including verifiable costs and statistics, must accompany every appeal. Letters of intent to appeal or appeal packages lacking such documentation shall not be accepted or considered to be an appeal.

(o) Hospitals may not request and the Commissioner shall not consider any pending or further appeals for an adjustment to rates of payment based on costs associated with technology advances or changes in medical practice or universal precautions.

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Supersedes TN 95-26 Effective Date JAN 01 1997

86-1.65 Medicaid Disproportionate Share Payments

(a) For the rate periods commencing January 1, 1991 and thereafter, Medicaid disproportionate share payments shall be made to hospitals to reimburse a portion or all of the costs associated with serving those patients unable or unwilling to pay for services rendered.

(b) Definitions.

(1) For rate periods prior to January 1, 1997, need shall be defined as inpatient losses from bad debts reduced to cost and the inpatient costs of charity care increase by any deficit of such hospital from providing ambulatory services, excluding any portion of such deficit resulting from governmental payments below average visit costs, and revenues and expenses related to the provision of referred ambulatory services. Grants received to finance operating expenses, and the income and, where appropriate, principal, from those endowment funds and special purpose funds whose use is restricted to pay for the costs of care provided to those unable to pay, shall also be considered in the calculation of outpatient deficits and inpatient bad debts and charity care. Base year need shall be adjusted for a facility that has entered into a comprehensive affiliation agreement on or after January 1, 1992 and prior to January 1, 1997 to assure continuation of inpatient services in a hospital in a medically underserved area, to incorporate the additional cost of bad debt and charity care associated with patient referrals resulting from the new comprehensive affiliation. To obtain such an adjustment the facility must provide documentation, acceptable to the Commissioner, that demonstrates and quantifies the additional cost of bad debt and charity care associated with such new patient referrals. This adjustment must be requested and supporting documentation must be submitted in writing by the facility 60 days prior to the rate period for which the base year need being adjusted is used. Base year need for any facility replaced as a primary affiliate through a comprehensive affiliation agreement shall be adjusted by the same amount to reflect savings associated with the decreased cost of bad debt and charity care referrals from a former affiliate. The allowable additional cost or savings from bad debt and

TN 97-06 Approval Date JUN 06 2001
Supersedes TN 92-36 Effective Date JAN 01 1997

charity care need shall be added to or subtracted from the base year need until such time as the additional bad debt and charity care need becomes part of the base year need. Thereafter unadjusted base year need shall be used for purposes of regional disproportionate share pool distributions in accordance with subdivision (k) of this section. For rate periods commencing January 1, 1997 and thereafter, uncompensated care need shall mean losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient and ambulatory services, excluding referred ambulatory services. The cost of services provided as a employment benefit or as a courtesy shall not be included.

(2) For rate periods prior to January 1, 1997, targeted need shall be defined as the relationship of need to net patient service revenue expressed as a percentage. For rate periods commencing January 1, 1997 and thereafter, targeted need shall be defined as the relationship of uncompensated care need to reported costs expressed as a percentage. Reported costs shall mean costs allocated as prescribed by the Commissioner to general hospital inpatient and outpatient services, excluding referred ambulatory services. Targeted need shall be determined based on base year data and statistics for the calendar year two years prior to the distribution period.

(3) For rate periods prior to January 1, 1997, net patient service revenue shall be defined as net patient revenue attributable to inpatient and outpatient services excluding referred ambulatory services. Need shall be adjusted as provided in this subdivision. Net patient service revenues shall be adjusted for a facility that has entered into a comprehensive affiliation agreement on or after January 1, 1992 to assure continuation of inpatient services in a hospital in a medically underserved area to incorporate the additional revenues associated with patient referrals resulting from the new comprehensive affiliation. A comprehensive affiliation agreement shall mean an agreement by a hospital to serve as the primary source of physicians and residents for another hospital. To obtain such an adjustment, the facility must provide documentation, acceptable to the Commissioner, that demonstrated and quantifies the additional revenue associated with such new patient referrals. This adjustment must be requested and supporting documentation must be submitted in writing by the facility 60 days prior to the rate period for which the revenue being adjusted is used. Net patient service revenues for an facility replaced as a primary affiliate through a comprehensive affiliation agreement shall be adjusted by the same amount to reflect a reduction in revenues associated with decreased referrals from a former affiliate. The allowable additional or reduced revenue shall be added or subtracted from net patient service revenue until

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